Federal Update for August 2-15, 2016

Air Force Installation Access

Gate ID Needed in MN/MO/WA/AS

Beginning 15 AUG, identification cards or driver's licenses issued by Minnesota, Missouri, Washington state or American Samoa will no longer get people past the gate at Air Force installations. The Air Force said 4 AUG that those identifications don't meet the security and data-collection guidelines required by the Real ID Act. That law aims to improve the reliability of state-issued identification documents, and help stop people from using fake IDs. People with cards from those states and American Samoa can use an alternate form of identification, such as a valid passport, an employment authorization document with a photograph, or an ID card issued by other federal, state or local government agencies that includes a photo and biographic information. Individuals without a DoD ID card will be subject to a background check. Anyone who does not have the required documentation will not be able to come on base without an escort. [Source: Air force Times | August 8, 2016 ++]

TRICARE Medical Identity Theft

Watch for Signs

Did you know that health care is the number one target, nearly as much as retail, finance, and banking combined, for identity theft and fraud? Your health information is important to you and your health care provider. But in the wrong hands, it can be valuable to someone else. Would you know if someone stole your medical identity? Identity theft affects millions of people every year. The Federal Trade Commission offers several steps you can take to make sure your health care information remains secure.

- First, read your medical and insurance statements regularly and completely. They can show warning signs of identity theft. Look for services you did not receive or providers you did not see. This is like seeing charges on your credit card statement that were not yours.
- Next, read the Explanation of Benefits (EOB) statement or Medicare Summary Notice that your health plan sends after each treatment. Again, check the name of the provider, the date of service, and the service provided. Do the claims paid match the care you received? If you see a mistake, contact your health plan and report the problem.
- You should also watch for bills if you know part of your care was not covered. If a bill doesn't show up when you expect it, look into it.

Being cyber fit requires us to be mindful of your health information even when you're not using health IT. You are the center of your healthcare. Empower yourself to protect your information. For more information about cyber fitness, visit the TRICARE website at http://www.tricare.mil/Privacy/Cyberfit. [Source: TRICARE News Release | August 4, 2016 ++]

VA Medical Staff Update

Attrition Rate Increase

Clinical professional positions at the Veterans Health Administration have continued to face rising losses, a 29 JUL report from the Government Accountability Office has found. The report examined the attrition rate of five clinical jobs that the VHA considers in short supply—including physicians, nurses and psychologists—and found that the rate of professionals leaving the agency had increased by 31 percent, from 5,897 positions in 2011 to 7,734 in 2015. The report comes at a time in which the VHA is trying to better its response time to an increasing number of veteran health care issues. "Despite its hiring efforts, we and others have expressed concerns about VHA's ability to ensure that it has the appropriate clinical

workforce to meet the current and future needs of veterans, due to factors such as national shortages and increased competition for clinical employees in hard-to-fill occupations," the report said in a letter to Sen. Richard Blumenthal, D-Conn., the ranking member of the Senate Committee on Veterans' Affairs.

The five shortage positions accounted for nearly half of the total clinical positions lost in 2015, driven largely by voluntary resignations and retirements. The report found that professionals in the clinical shortage positions that left the VHA cited the following in exit interviews:

- 28 percent said advancement had played a role, while 21 percent said that dissatisfaction, including "such as concerns about management and obstacles to getting the work done, was the primary reason they were leaving."
- 71 percent said no single event convinced them to leave the VHA.
- Half of the respondents said they were generally satisfied with senior management, while 31 percent said they were not.
- 65 percent were generally satisfied with their jobs, while 25 percent said they were not.
- 50 percent said they would have stayed if they had benefits like alternative or part-time schedules or student loan repayment or tuition assistance.

The report is part of an annual assessment of the five clinical positions with the largest staffing shortages in the VHA, which is required by The Veterans Access, Choice, and Accountability Act of 2014. The GAO didn't offer any recommendations on how to stem the losses, but the Department of Veterans Affairs said in the report that the attrition levels had returned to the pre-recession rates of 2006-2007 after they declined due to the economic downturn. The agency also said the shortage mirror those in the private health care sector, where there is increased competition to fill physician and nurse shortages, but that it was still working to address them in-house. "VHA is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the VA health care system," the agency said in response to the report. [Source: Federal Times | Carten Cordell | August 1, 2016 ++]

VA Emergency Care Update

1 in 3 Claim Denials in FY 2014

Fearing the Department of Veterans Affairs would deny his claim, a disabled Pittsville Gulf War veteran avoided going to his nearest emergency department during a recent medical scare. "My pillow was covered in blood," said Jerry Zehrung, who has lived with a constant infection risk since having his hip resurfaced eight years ago. "My wife looks at me and she's panicked," Zehrung said. "Her first instinct was let's get you to the emergency room. And my first instinct was who's going to pay the bill." NewsChannel 7 Investigates discovered a VA executive admitting there are a large number of denied veterans' emergency treatment claims.

Testifying before a Veterans' Affairs subcommittee in February, VA Assistant Deputy Undersecretary for Health for Community Care, Dr. Baligh Yahia, told members of congress during the 2014 budget year approximately 30 percent of the 2.9 million emergency claims filed with the VA were denied. Of those 870,000 denied claims, a VA representative confirmed 7,000 of those claims came from Wisconsin veterans. In breaking down the denied claims during his testimony, Yahia said 89,000 were late. Another 98,000 were not emergencies. 140,000 were denied because a VA facility was determined to have been available. And 320,000 more claims were denied because the Veteran was determined to have other health insurance that should have paid for the care. In total, about one-out-of-every-three veterans' emergency claims were denied during the 2014 budget year. "Many of these denials are the result of inconsistent application of the "prudent layperson" standard from claim to claim and confusion among Veterans about when they are eligible to receive emergency treatment through community care," Yahia testified on 2 FEB

While Zehrung did not know the exact numbers, he knew many of his fellow veterans had seen their emergency claims denied. Fearing the possible billing risk, the morning of his medical scare Zehrung did not travel from his Pittsville home to the nearest emergency department about 15 miles away in Wisconsin Rapids. The closest VA approved ER Is more than 120 miles away in Madison. Because he knew the bill would at least be covered more than 40 miles away at the Tomah VA's urgent care, Zehrung had his wife drive him more than twice as far as the closest emergency care. "I've heard too

many horror stories by too many people. And the stress that it creates for a family. No veteran should face," Zehrung said. “The prospect of putting my family in that situation is untenable.”

ONE VETERANS NATIONAL APPEAL

One of those horror stories is retired Minnesota Air force veteran Richard Staab. From 1952 to 1956 the now 84-year-old was a ground radio operator. After a heart attack and a stroke left Staab unable to communicate, court documents tell the story of how the veteran ended up at several non-VA medical facilities between 2010-2011. Eventually, Stabb needed open heart surgery. However, when it came time to pay $48,000 in bills, the VA countered saying Staab should have received their permission before going to the non-VA facilities, and because he had Medicare, the VA took the position they did not have to pay. “It depleted his life savings,” one of Staab’s lawyers Jacqueline Schuh said. “And he's on a very low fixed income. So he literally has nothing else."

Three appeals and nearly six years after Staab suffered his heart attack, the United States Court of Appeals for Veterans Claims agreed to hear his case. In April, the three judge panel sided with the veteran, saying the VA had violated federal law since 2009, by using an out of date regulation for years to deny veteran's emergency claims. Whether or not Staab had Medicare, the judges said the VA should have paid his bills and would have to now have to reimburse Staab. “Was very elated, as we both were, to see what the initial outcome was of the appeal," Staab said. But that victory would be short lived. This month, Staab learned the VA had appealed the decision to the United States Court of Appeals.

Schuh feels the VA’s repeated appeals are because the Staab case would set a precedent that could cost the VA to have to repay a massive amount of denied claims. During Yihia’s congressional testimony, the VA executive said the nearly one-out-of-three veterans’ emergency care claims denied during the 2014 budget year totaled $2.6 billion “I don’t think it’s his particular case so much as it is the ramifications of how many people will be opening up their cases from 2010 to the present to seek that reimbursement,” Schuh said. "If the decision is affirmed, and it's not appealed further, and they pay him out, the question is going to be whether he is alive to receive the payment,” Schuh added. “If he's not alive to receive the payment there's no benefit to the family after either." Because of the ongoing litigation, VA representatives declined to comment to News Channel 7 Investigates on their appeal of the Staab Case, other than citing what is detailed in their appeal.

COLLECTING ON VETERANS UNPAID BILLS

A former collection agent, named Susan, says she was at first surprised, and then saddened to discover much of her job was spent calling veterans and their loved ones about unpaid bills. "Most of the time it was the VA denying their medical benefits,” Susan said. “They'd take them in and assume the VA was going to take care of that. And they come to find out the VA has stipulations. There's a 72 hour rule. You don't contact the VA within 72 hours they can deny that claim.” “It was very sad,” Susan said. “Because my husband is a veteran.” Susan is Susan Zehrung, Jerry Zehrung's wife. She found herself in a similar situation to all those veterans and loved ones she spent years on the phone with, the morning she thought her husband was in the middle of a medical emergency. "And he was more concerned about wanting to call the VA, then wanting to go to an emergency room closer,” Susan Zehrung said. “And he seemed to get the run around. Speaking to the person on the phone she said I'm not a doctor. I can't tell you not to go to the emergency room.” "To me America should be taking care of their veterans. They're the ones who will run into any fire fight for their country,” Susan added. “And to not have the American people and the government backing them on their health care costs is ludicrous.”

BUYING A SAFETY PLAN

Before his medical scare, Jerry Zehrung thought if an emergency ever happened he would buy an extra insurance plan. While that is allowed under the federal health care law, VA care meets the requirement for having health insurance. That means veterans are not eligible for assistance to lower a second plan's cost. "All I'm asking for is every vet in our country get the same rights, and get treated the same way as every other American,” Zehrung said.
In late June, NewsChannel 7 Investigates was there as Zehrung took that concern to staff from the offices of Sen. Tammy Baldwin (D-WI), Sen. Ron Johnson (R-WI) and Rep. Sean Duffy (R-WI).

During the meeting Zehrung was presented with a possible law change. Known as the Improving Veterans Access to Care in the Community Act, which Baldwin is sponsoring, Baldwin's representative told him the legislation includes creating a cost-sharing system for emergency care. However, Zehrung said the bill does not address his concern. "If you obtain health

insurance from the Veterans Administration, the way the legislation reads now, you cannot purchase a health insurance plan for yourself," Zehrung said. "And I don't quite understand that."

Like many veterans, Zehrung is confused by a system that cannot guarantee those who served a grateful nation will have their emergency bills paid. "Unfortunately sometimes the definition of thanks and grateful get lost in translation," Zehrung said

In his case he is grateful his bleeding ear was not an emergency. But with gratitude comes the daunting realization: if he had gone to his closest hospital, today he would likely be looking at have to pay the bill out of his own pocket. "How often do you think these veterans are suffering life threatening emergencies?" Zehrung asked. "And their first thought isn't I need help. It's how is the bill going to be paid." In a statement to NewsChannel 7 Investigates, Duffy said, ""The VA is a broken system, but the answer is not to expose our veterans to the disaster that is Obamacare. We need a VA that actually follows through on that promise. That's why I'm fighting to reform the VA and hold its leaders accountable."

THE VA RESPONSE

In a response to NewsChannel 7 Investigates questions, VA spokesperson Sabrina Owen released the following responses to our questions on behalf of VA representatives:

Question 1: *According to Dr. Yehia's February 2016 testimony, in FY2014 30% of the 2.9 million emergency treatment claims filed with VA were denied. Of those 30 % denied claims, what percentage and number of Veterans represent the state of Wisconsin?*
Response 1: Of the 30% emergency treatment claims filed that were VA denied in FY14, approximately 3% were from the state of Wisconsin. There were approximately 7,000 unique Veterans within this 3% population.

Question 2: *Why won't the VA simply pay for Veterans Emergency Care at non-VA facilities?*
Response 2: VA's authority to reimburse for unauthorized emergency care furnished by non-VA facilities is established in statute. Even if the Staab decision is upheld, the statutory authority does not set forth a payment methodology or payment limitations necessary for VA to implement the decision. Therefore, VA must follow legal procedures to implement regulations that would allow it to process payments for claims impacted by Staab, i.e. claims for reimbursement where a Veteran has coverage under a health-plan contract. Further, the case is in active litigation and may be appealed to the Federal Circuit, which could overturn the Staab decision.

Question 3: *Does the VA have an official response to the Richard Staab case?*
Response 3: VA's position is set forth in its filings before the Veterans Court.

Question 4: *Reporter would like clarification from the VA on if his understanding of the Richard Staab case is accurate – please provide a statement summarizing the VA response.* Here is the reporter's summary of understanding:" In April the judges sided with Mr. Staab, saying the VA failed to revise their emergency medical expense reimbursement regulations, according to a 2009 congressional mandate. It now appears, the VA is appealing this decision. For quick background the VA would not pay Mr. Staab's $48,000 bill for emergency care when he had a heart attack/stroke and ended up having open heart surgery because he did not receive the VA's pre-approval for this non-VA hospital care while Mr. Staab was incapacitated."
Response 4: VA denied Mr. Staab's claims for reimbursement under 38 U.S.C. § 1725(b)(3)(B) and 38 C.F.R. §17.1002(f) because he was covered by Medicare. Because this is an active litigation matter, we decline to state more at this time.

Question 5: *Why is the VA fighting the ruling of the Richard Staab case?*
Response 5: VA's position is set forth in its filings before the Veterans Court. Because this is an active litigation matter, we decline to state more at this time.

Question 6: *Also a point of clarification – we have heard from veterans who say when they call the VA they're told to go to the ER – only to be told later the VA determined their emergency care bill would not be reimbursed. Who is the "they" making the reimbursement decision? What is the official name of that position?*

Response 6: When a Veteran calls, he/she may receive a recorded message which advises him/her to call 911 or report the closest emergency if he/she is experiencing a life threatening emergency. This statement is to ensure that the Veteran takes the necessary steps to receive emergency care. It is also the same message found in the community when a patient receives a recorded line at his/her physician's office. Such a message does not commit VHA to payment of any associated claim. VHA Office of Community Care must still make an eligibility determination for emergent care based on current regulatory authorities. [Source: WSAW TV |News Channel 7 | Matthew Simon | Jul 28, 2016 ++]

VA Pain Care Update

Study Shows Improvement with Age

Older military veterans frequently show improvements in pain intensity over time. However, opioids, some mental health conditions and certain pain diagnoses are associated with lower likelihood of improvement, according to research reported in The Journal of Pain. The aging veteran population is at especially high risk for persistent pain. Unfortunately, little is known about factors linked with positive and negative outcomes over time. Further, older adults have the highest prevalence of long-term use of pain medications, including opioids.

Researchers at the Department of Veterans Affairs Center to Improve Veterans Involvement in Care and Oregon Health & Science University sought to identify clinical and demographic factors associated with changes in pain scores over time in a national cohort of veterans 65 and older with chronic pain. They hypothesized that older age and comorbid mental health disorders would be associated with less improvement in pain conditions over time. The study examined a database of some 13,000 veterans receiving treatment in the VA system who had elevated numeric rating pain scores and had not been prescribed opioids. They measured the percentage decrease over 12 months in average pain intensity scores and the time to sustained improvement.

Results showed that nearly two-thirds of these patients met criteria for sustained improvement during the 12-month follow up period. A key finding was initiation of opioid therapy was associated with lower likelihood for sustained improvement. Other factors associated with poor improvement were service-connected disability and mental health problems, chronic low back pain, neuropathy and fibromyalgia/myofascial pain diagnoses. "We found that older veterans often show improvements in pain intensity over time, and that opioid prescriptions, mental health conditions and certain pain diagnoses are associated with lower likelihood of improvement," said Steven K. Dobscha, MD, lead author and professor of psychiatry at Oregon Health and Sciences University. "Further, the oldest group of veterans within the sample demonstrated the most improvements in pain intensity. This supports prior research indicating that as age increases, patterns and perceptions of pain may change and suggests that many older people with pain adjust and cope better over time."

Although two-thirds of the sample experienced pain improvement over time, a substantial minority of veterans did not show reductions in pain intensity, and some had exacerbated pain. Dobscha said the study findings call for further evaluation of pain outcomes in older adults and that in particular there is a need for more research to study relationship between prescription opioids and treatment outcomes over time. [Source: American Pain Society | July 28, 2016 ++]

VA Intermediate Care Technician

Former Military | Career Field

Recently discharged military medics across the country now have the opportunity to seek comparable employment with VA, thanks to a program which aims to integrate them as clinical staff in VA's emergency departments. The program's mission is twofold — to develop a pipeline of well-trained clinical staff into the VA and to cultivate a career transition for former medics into civilian employment in the medical career field.

In 2011, VA introduced a pilot program to explore a potential career field in its medical centers, the Intermediate Care Technician (ICT). The idea sprang from the department's desire to recruit former military medics and corpsmen to capitalize on their tremendous knowledge, skills and experience. Beyond active duty there are few, if any, equivalent civilian health care positions that allow these Veterans to utilize their training without additional academic preparation.

VA began recruiting former military medics and corpsmen to fill these positions in 2012. The ICT role was designed to capitalize on the training and skills of the former medics and corpsmen to provide a higher level of clinical support to both nursing and medicine.

To test the feasibility of the new position, a one-year pilot program was implemented in 15 emergency departments, each with three ICTs. The pilot facilitated the hiring of former medics and corpsmen to fill the positions. VA received over 400 applications for 45 vacancies. Throughout the pilot phase, VA completed proficiency and competency testing for ICTs in a variety of skills: taking vital signs; completing point-of-care testing including EKGs, rapid flu/strep, and urine testing; drawing blood samples; placing IVs, NG tubes and catheters; eye and ear irrigation; simple abscess incision and drainage; suturing, splinting and wound care. ICT responsibilities range from expediting the flow and efficiency of fact track areas within the emergency department, rooming and prepping patients for evaluation, confirming that tests initiated in triage are completed, coordinating the patient to different venues and completing their discharge process.

Program administrators paid special attention to the impact ICTs had on patient care and satisfaction. The pilot demonstrated that the ICT role was a success. Pilot sites reported improved patient processing and increased productivity of emergency department staff as a whole. In addition, ICTs reported satisfaction and gratitude for the chance to use their knowledge and skills for Veteran care. Additionally, Veteran patients easily identified with and accepted the care provided by the ICTs.

Upon completion of the pilot program, facilities not included in the first phase expressed an interest in hiring ICTs. VA is now in the process of expanding the ICT role as a special classification. VA is also creating a career pathway for ICTs to attain licensed professional roles through advanced education, with the goal of long-term VA employment, supporting VA's ongoing mission of providing quality care to Veterans. For information about opportunities in the ICT career field, visit VA Careers and read more about the ICT pilot program career opportunities and application requirements at www.vacareers.va.gov/careers/intermediate-care-technician/index.asp. [Source: This Week At VA | July 29, 2016 ++]

VA End-Of-Life Study

Results for Non-Cancer Conditions

Although most patients in the United States die of another condition, cancer is the focus of most end-of-life care studies. The result, according to new VA-led research, is that families reported better quality of end-of-life care for veterans with cancer—and for dementia—than for those with end-stage renal disease (ESRD), cardiopulmonary failure or frailty. The likely reasons? Patients with cancer or dementia had higher rates of palliative care consultations and do-not-resuscitate orders, and fewer died in hospital intensive care units, according to the report published online by *JAMA Internal Medicine* and to coincide with a presentation at AcademyHealth's Annual Research Meeting in June.[1] The study looked at patients who died at 146 inpatient facilities within the VA healthcare system and was led by researchers from the Boston VAMC.

"We need to broaden our attention to improve the quality of end-of-life care for all patients, not just those with cancer or dementia," said lead author Melissa Wachterman, MD, MPH, MSc, who in addition to her VA role is at Harvard Medical School and Dana-Farber/Brigham and Women's Cancer Center. "Our study shows that, while there is room for improvement in the quality of end-of-life care for all patients, this is particularly true for patients dying of heart failure, chronic lung disease and renal failure."

Medical records and family surveys were examined for more than 34,000 patients who died at the VA between 2009 and 2012. Veterans with end-stage renal disease, cardiopulmonary failure —congestive heart failure or chronic obstructive pulmonary disease —and frailty were far less likely to receive palliative care consultations than patients with cancer or dementia. In fact, one-third of those patients died in the intensive care unit, more than twice the rates for those with cancer or dementia. Those veterans also were less likely to have do-not-resuscitate orders. On the other hand, death in a hospice unit—the inpatient setting with the highest level of family-reported quality —was more common among patients with cancer and those with dementia than among those with end-organ failure or frailty.

Overall, results indicate that patients who had been seen by a palliative care doctor received better end-of-life care based on reports from their families. “Increasing access to palliative care at the end of life may improve the quality of end-of-life care for those with heart, lung and kidney diseases—a group that is rapidly growing with the increasing number of aging Americans dying of these conditions,” Wachterman said. Among 57,753 veterans who died, about half of the patients with ESRD (50.4%), cardiopulmonary failure (46.7%) or frailty (43.7%) received palliative care consultations, compared with 73.5% of patients with cancer and 61.4% of patients with dementia.

In addition, about one-third of patients with ESRD (32.3%), cardiopulmonary failure (34.1%) or frailty (35.2%) died in an intensive care unit—usually associated with poorer end-of-life care. That rate was much higher than for patients with cancer (13.4%) and dementia (8.9%), study authors reported.

Family reports of excellent quality of end-of-life care were similar for patients with cancer (59.2%) and dementia (59.3%) but lower for patients with ESRD and cardiopulmonary failure (both 54.8%) or frailty (53.7 percent).
Study authors suggested several steps to improve disparities in overall quality of end-of-life care, including increasing access to palliative care and inpatient hospice for patients with ESRD, cardiopulmonary failure or frailty, and more discussions with those patients about preferred setting of death.

The researchers questioned whether diagnosis-related differences in patient and/or family preferences explained some of the differences in care perception. “However, we found that the groups of patients who were less likely to receive palliative care consultation, less likely to have a do-not-resuscitate order, and more likely to die in the ICU—those with end-organ failure or frailty—also had lower rates of families reporting that their health care professionals offered the medical treatment that the patient and family wanted,” they pointed out. “This finding is more consistent with the notion that some diagnosis groups experience a greater mismatch between the care they receive and their underlying preferences, rather than diagnosis groups exhibiting sharp differences in preferences.”
Differences in perceptions regarding the treatability of different serious conditions and the reversibility of their associated acute complications were factors, however.

The researchers described how, for patients with end-organ failure, the clinical trajectory usually includes acute exacerbations that are temporarily responsive to interventions. When those interventions are no longer helpful, however, “it can be a difficult transition for patients, families and health care professionals. Therefore, differences in quality by diagnosis may reflect a failure to accept impending death and de-escalate aggressive treatment in conditions characterized by chronic progressive end-organ failure.” While use of measures of treatment intensity as quality indicators generally has been limited to the field of oncology, study authors suggest that, because of the frequency of high-intensity care for patients with end-organ failure, the measures could be used as quality indicators among patients dying of other conditions as well. One disturbing aspect of the research, according to the report, is the high prevalence of pain among veterans dying in the hospital. Most, more than 75%, had pain in the last month of life, with more than half reporting frequent uncontrolled pain.

Another recent study found that use of palliative care was highly inconsistent in veterans dying of cancer. For example, patients with brain cancer were more likely to receive palliative care than those with kidney cancer. In addition, patients older than 85 were less likely to receive palliative care than patients between the ages of 65 and 69, while patients older than 80 were more likely to receive hospice care than younger patients. Those with brain cancer, melanoma or pancreatic cancer were more likely to receive hospice than patients with prostate or lung cancer.

At the same time, patients receiving VA care were less likely to receive hospice care for the minimum recommended three days, compared with those in Medicare or in other contracted care paid for by VA. VA patients first received hospice care a median of 14 days before death, compared with patients in VA-contracted care who entered hospice a median of 28 days before death, even though VA cancer patients are allowed to continue to receive curative treatment while in hospice care. “Ideally, there shouldn’t be any difference in timing of this care,” said lead author Risha Gidwani, DrPH, a health economist at Veterans Affairs Palo Alto Health Economics Resource Center and a consulting assistant professor of medicine at the Stanford University School of Medicine. “Patients should receive a service based on their clinical need, not due to healthcare system factors.”

The situation might be even more serious for patients without cancer, according to the Boston VAMC study. “Our finding that patients with end-organ failure and frailty had rates of frequent, uncontrolled pain similar to those of patients with cancer (a group generally considered to be at high risk for pain) suggests another opportunity to improve care,” study authors wrote. “The lower rates of uncontrolled pain in patients with dementia must be viewed with caution, since pain is often underappreciated in this population, even by family members.”

Overall, the researchers suggested, applying protocols developed for cancer and dementia at the end of life to other conditions could substantially improve end-of-life quality. “While there is room for improvement in end-of-life care across all diagnoses, family-reported quality of end-of-life care was significantly better for patients with cancer and those with dementia than for patients with ESRD, cardiopulmonary failure or frailty,” they concluded. “This quality advantage was mediated by palliative care consultation, do-not-resuscitate orders and setting of death. Increasing access to palliative care and increasing the rates of goals of care discussions that address code status and preferred setting of death, particularly for patients with end-organ failure and frailty, may improve the quality of end-of-life care for Americans dying with these conditions.”

An accompanying editorial notes that the VA health system has invested in “the rapid expansion of palliative care services and a reporting process that provides the data for this study and ongoing quality metric assessments.”
Specifically, the VA has supported integration of palliative care services with disease-focused treatment to reduce the “terrible choice” of treatment focused on disease as opposed to a comfort approach to care according to commentary by Stacy M. Fischer MD of the University of Colorado School of Medicine at the Anschutz Medical Campus in Aurora, CO; David Bekelman, MD MPH, of the University of Colorado and the Denver VAMC; and F. Amos Bailey, MD, of the University of Colorado and the Birmingham/Atlanta Geriatric Research, Education, and Clinical Center at the Birmingham, AL, VAMC.

“While early access to palliative care services may remain the goal, current and future workforce shortages will continue to limit access,” the commentators wrote. “Despite the resources the VA health system has invested to develop well-trained palliative care teams and units, extending specialty palliative care to all patients facing life-limiting illness would quickly overwhelm these resources. So while efforts to expand the workforce both within and outside the VA health system are critical, further research is needed to understand what services and interventions are truly helpful and how they can be provided by the primary care teams.”

Not every patient needs a palliative care consultation with a specialist palliative care physician, nurse and social worker. Fischer, Bekelman and Bailey suggest understanding which patients need which components and expanding primary palliative care might be the only ways to meet the growing need for patients with advanced progressive medical illnesses. [Source: U.S. Medicine | Brenda L. Mooney | August 2016 ++]

VA Pension Update

One Civil War Pension Still Active

The Civil War ended more than 150 years ago, but the U.S. government is still paying a veteran's pension from that conflict. "One beneficiary from the Civil War [is] still alive and receiving benefits," Randy Noller of the Department of Veterans Affairs confirms. Irene Triplett – the 86-year-old daughter of a Civil War veteran – collects $73.13 each month from her father's military pension. The identity of Triplett was first reported by The Wall Street Journal in 2014. "VA has an obligation to take care of our nation’s veterans no matter how long. It is an honor to serve and care for those who served our country," Noller explained in an email to U.S. News.

As the United States continues fighting the lengthiest war in its history – the campaign in Afghanistan – it is worth considering how long the consequences of U.S. military action reverberate. The U.S. government pays out veterans' benefits to spouses and dependents of former soldiers. A subsection of Title 38 of the United States Code spells out the rules and regulations for their allocation, including for the Civil War, even though that now only applies to one person in the country, Triplett. "Whenever there is no surviving spouse entitled to pension," as there is not in Triplett's case, "the Secretary shall pay to the children of each Civil War veteran who met the service requirements of section 1532 of this title a pension at the monthly rate of $73.13 for one child... A veteran met the service requirements of this section if such veteran served for 90 days or more in the active military or naval service during the Civil War," the code notes.

"The promises of President Abraham Lincoln are being delivered, 150 years later, by President Barack Obama," then-Veterans Affairs Secretary Eric Shinseki said in a speech in 2013. "And the same will be true 100 years from now—the promises of this president will be delivered by a future president, as yet unborn."

U.S. Veterans and Dependents on Benefits Rolls as of May 2016

	VETERANS	CHILDREN	PARENTS	SURVIVING SPOUSES
Civil War	-	1	-	-
Spanish-American War	-	46	-	42
Mexican Border	-	3	-	6
World War I	-	1,590	-	1,236
World War II	144,938	9,360	10	178,251
Philippines	1,776	155	3	2,598
Korean Conflict	181,893	2,207	25	74,041
Vietnam Era	1,525,400	4,570	1,198	251,543
Gulf War[1]	1,990,094	4,488	1,788	26,799
Peacetime	710,773	1,382	713	36,048
Non service-connected[2]	292,297	10,175	-	193,442
Service-connected[2]	4,262,577	13,627	3,737	377,122

1. For compensation and pension purposes, the Persian Gulf War period has not yet been terminated and includes Veterans of Operations Iraqi Freedom, Enduring, and New Dawn.
2. This total includes peacetime veterans receiving benefits.
Source: Department of Veterans Affairs

Triplett's father was Mose Triplett, born in 1846. He joined the Confederate army in 1862, but later deserted and signed up with the Union. His first wife died and they did not have any children. He later married Elida Hall who was at least 50 years younger. They had five children, three of whom did not survive infancy. But Irene, and her younger brother Everette did. Mose Triplett was 83 when Irene was born, nearly 87 when her brother Everette came along. Mose Triplett died a few days after returning from the 75th anniversary of the Battle of Gettysburg in 1938. His wife and daughter went to go live in public housing, and his son ran away. Elida Triplett died in 1967. Everette Triplett died in 1996.

Irene Triplett did not have a happy childhood, she recalled to The Wall Street Journal in a 2014 interview. "I didn't care for neither one of them, to tell you the truth about it," she said referring to her parents. She noted she was often abused. "I wanted to get away from both of them. I wanted to get me a house and crawl in it all by myself," she said. When U.S. News reached out to the Department of Veterans Affairs for updated information on Triplett, a spokesman indicated the family did not wish to be contacted. May-December romances are not unheard of in 2016, but in the case of Mose Triplett and his second wife, based on past comments from Irene, and facts about American life at the time, there may have been very little romance in the union. "[There was] not much economic opportunity during this period," so many men would leave the area, Dan Pierce, a history professor at the University of North Carolina, Asheville, who specializes in the American South, explained in an email exchange with U.S. News. "Parents in this type of situation would encourage daughters, who perhaps cost more to feed than they provided to the economic well being of the farm, to marry (anyone) and relieve them of the expense."

While Triplett has outlived all the spouses of Civil War veterans, it is not by as long a period as one might think. The last Confederate widow, Maudie Hopkins died on Aug. 1, 2008, at age 93. The last Union widow, Gertrude Janeway, died Jan. 17, 2003, also at age 93. The last Civil War veterans themselves, both Union and Confederate, died in the 1950s. Both men were more than 100 years old. Since the Civil War's conclusion in 1865, the U.S. has been involved in numerous conflicts around the globe.

- The Spanish-American War was fought in 1898, yet there are 46 surviving children, and 42 surviving spouses, collecting benefits from the VA. The last veteran of the U.S.-Spain conflict over Cuba, Guam, Puerto Rico, and the Philippines, died in 1992 – Nathan E. Cook, aged 92.
- Some 1,590 surviving children and 1,236 surviving spouses of World War I veterans still collect benefits, as of May 2016. American involvement in the Great War occurred from 1917-18, after the war started in 1914 among European parties. The last surviving American World War I veteran was Frank Buckles, who died Feb. 27, 2011, at the age of 110. [Source: U.S. News & World Report | Curt Mills | August 8, 2016 ++]

VA Cardiac Rehabilitation Program

Increasing Life Expectancy

"I get to the point where I look forward to Joan calling me on Wednesday afternoons. You know three o'clock comes and I know I have to be near the phone and be ready for her call, and then I give her all my numbers. She'll check with me to see if I have any pain, how the week went and so forth, which I find is good," explained rural Veteran Oscar Bourbeau. Bourbeau participates in a new home-based cardiac rehabilitation program offered by the U.S. Department of Veterans Affairs (VA).

Scientific studies show that people who complete a cardiac rehabilitation program following a heart attack or bypass surgery can increase their life expectancy by up to five years, and have:

- 27 percent lower cardiac death rates,
- 25 percent fewer fatal heart attacks, and
- An improved quality of life.

Cardiac rehabilitation occurs in three phases. Phase 1 begins during inpatient hospitalization under physician management. Phase 2 is a medically supervised outpatient program that begins following discharge to slow or even reverse the progression of the underlying hardening and narrowing of the arteries due to plaque. Phase 3 is a lifetime maintenance program with periodic follow-up. Rural Veteran patient participation in sustained Phase 2 rehabilitation is a challenge due to limited transportation options, geographic barriers and lack of proximity to specialized cardiac facilities. To reduce these Veterans' barriers to care, VA piloted a home-based cardiac rehabilitation program which recently earned the distinction of being a VA Office of Rural Health (ORH) Rural Promising Practice, and is being rolled out nationwide due to patients' health outcomes and satisfaction.

This Rural Promising Practice enables Veteran patients to first meet in-person with a specialist to safely learn rehabilitation exercises, with subsequent sessions conducted at home. This model eliminates the need to travel multiple times a week to a rehabilitation facility for a sustained time frame, and enables patients to tailor the location and schedule of their ongoing 30-minute rehabilitation exercise sessions. Regularly scheduled phone calls with the rehabilitation specialist are dedicated to review curriculum that addresses risk factors, such as smoking cessation and proper nutrition. Other discussions focus on exercise, medication adherence and stress management. "The weekly calls are very beneficial because I have a plan and goals that really allow me to focus on getting my health back on track," stated program participant and rural Veteran Richard Howe.

Joan Walsh, a program nurse at Manchester VA Medical Center explained, "I've had some Veterans say I'm the devil on the shoulder or others you know, say I'm the angel on the shoulder." She added, "I hold them accountable for them taking control of their health, and making it better. I'm very proud of the Veterans and their dedication to this program, and to making their lives healthy."

To evaluate the success of a 12-week remote, home-based Phase 2 cardiac rehabilitation program compared to a traditional on-site program, researchers: reviewed its reach, effectiveness and implementation; compared clinical measures; and compared cost data. Results showed both health outcomes and costs were comparable with no negative impacts from remote care. In fact, rural Veteran patients who used home-based rehabilitation reported higher levels of satisfaction and were more likely to complete the program.

To learn more about the expanding Cardiac Rehabilitation Program pr, watch the three minute "Home-Based Cardiac Care for Rural Veterans" video at https://youtu.be/S3tl3vMaDJs. The Office of Rural Health oversees Rural Promising Practices as part of its portfolio of enterprise-wide initiatives. These 40+ initiatives help increase access to care for the 3 million Veterans living in rural communities who rely on VA for health care. To learn more, visit www.ruralhealth.va.gov or email rural.health.inquiry@va.gov. [Source: Veterans Health | In The spotlight | August 6, 2016 ++]

VA Suicide Prevention Update

2001-2014 VA Suicide Report

On 3 AUG, the VA released **Suicide Among Veterans and Other Americans 2001-2014**, a comprehensive analysis of veteran suicide rates in the United States in which VA examined more than 55 million veterans' records from 1979 to 2014. "While the number of suicides among all veterans is significant, what may not be known is that approximately 65 percent of all veterans who died from suicide in 2014 were 50 years of age or older," said John Rowan, National President of Vietnam Veterans of America. "Why is it that so many veterans, basically, take their lives by suicide? Last year, the Clay Hunt SAV Act, Public Law 114-2, was enacted to address the high suicide rate amongst the newer veterans but did not specifically address the older veterans. We call on the VA to increase its outreach and education efforts immediately so that the families of all veterans, especially our older veterans, are aware of this risk."

The VA must overcome all barriers to find the key—if indeed there is one—to preventing suicide in as many instances as possible among our veterans. All Americans must also realize that there is a very serious problem with veteran suicides and act upon it with a coordinated effort in our communities—with our fellow veterans, both young and old; our families; our friends; and with researchers and the agencies of government. As we have repeatedly stated, one veteran suicide is too many. And let's not fool ourselves with easy answers."

Since 2001, the rate of suicide among U.S. veterans who use VA services has increased by 8.8 percent, while the rate of suicide among veterans who do not use VA services increased by 38.6 percent. In the same time period, the rate of suicide among male veterans who use VA services increased 11 percent, while the rate of suicide increased 35 percent among male veterans who do not use VA services. In the same time period, the rate of suicide among female veterans who use VA services increased 4.6 percent, while the rate of suicide increased 98 percent among female veterans who do not use VA services. Go to www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf to read the report. [Source: VVA Web Weekly | August 5, 2016 ++]

VA Health Care System Update

Making Progress | Improving Access

On 4 AUG VA released results of The Joint Commission Special Focused Surveys on VA health care facilities. VA invited The Joint Commission to conduct unannounced, focused surveys at 139 medical facilities and 47 community-based outpatient clinics across the country to measure progress on VA access to care, quality improvements and diffusion of best practices across the system. The surveys also assessed barriers that may stand in the way of providing timely care to Veterans. Results indicate VA has made significant progress since The Joint Commission began its surveys two years ago.

"The Joint Commission is one of the most widely-respected health care organizations in the industry," said VA Under Secretary for Health Dr. David J. Shulkin. "Their analysis shows that VA as national healthcare leader is making progress in improving the care we provide to our Veterans. This affirms our commitment to providing both excellent health care and an exceptional experience of care to all Veterans served."

The Joint Commission assessed processes related to timely access to care; processes that may potentially indicate delays in care and diagnosis; processes related to patient flow and coordination of care; infection prevention and control; the environment of care; and organizational leadership and culture. For the survey, VA's Veterans Health Administration provided organization-specific data addressing performance in the key areas targeted for review. This data allowed surveyors to focus on areas of greatest risk for each organization and to validate whether the VA-provided data reflected observed practice. The survey provided an opportunity to recognize patterns across the organization, to make an

assessment about the system as a whole and identify solutions to system-wide issues that are best addressed through internal processes.

"We commend VA for being proactive by requesting The Joint Commission to conduct unannounced site visits at all their medical centers to review and evaluate their efforts to improve access and quality of care," said Dr. Mark Chassin, President and CEO of The Joint Commission. "VA was the first system ever to request an assessment with an important focus on access so that deficiencies could be identified and rapidly addressed. The Joint Commission will track and report on the extent to which improvements were sustained, when the same facilities undergo their triennial accreditation surveys. To date, results from 57 hospitals that have undergone full accreditation are promising. We are pleased with VA's ongoing commitment to quality improvement and patient safety." Among the top findings:

- **Access to Care–**Facilities have seen improvements in providing patient appointments: Improvement efforts that were undertaken include leadership teams utilizing data to better understand where particular bottlenecks were and taking corrective actions. As the Joint Commission continues the regularly scheduled triennial surveys of VHA facilities after the special surveys were completed, the findings are encouraging. For example, as of April 1, 2016, 57 facilities have undergone follow-up surveys. Of these 57 sites, only one facility was found to have a repeat requirement for improvement (issue) related to patient access. Staffing continued to be a challenge in this area, but as new staff was hired, the wait times for appointments were more effectively addressed.
- **Choice Act**: Early discussions with Veterans indicated a strong preference, and even a loyalty, for their "own" VHA organization, even if it would mean waiting longer to be seen. VHA facilities and Veterans also report that many times appointments in the community could not be made any earlier than would have been possible inside VA.

Efforts to Improve Veterans Access to Care

- In 2014, VA introduced MyVA. MyVA is the largest transformation in the history of VA, which focuses on the needs of Veterans. As part of that transformation, in 2016, VA's Veterans Health Administration established and launched MyVA Access. MyVA Access also puts Veterans more in control of how they receive their health care.
- VA is moving to incorporate same-day access to primary care and mental health services for Veterans when it is medically necessary. At present, 39 VA facilities offer same-day appointments.
- A new smart phone app called the Veteran Appointment Request App has been developed and is currently being piloted. This app allows Veterans to view, schedule and cancel primary care and mental health appointments as well as track the status of the appointment request and review upcoming appointments. VA expects to make the app available to all Veterans by early 2017.
- Website enhancements are underway that will allow Veterans to check wait times in real time wherever they live – this includes a new, easy-to-use scheduling software program. The new program is being piloted and is expected to reduce scheduling errors and enhance VA's ability to measure and track supply, demand and usage.
- Nationally, VA completed more than 57.85 million appointments from July 1, 2015 through June 30, 2016. This represents an increase of 1.1 million more appointments than were completed during the same time period in 2014/2015.
- From FY 2014 to FY 2015, Community Care appointments increased approximately 20 percent from 17.7 million in FY 2014 to 21.3 million in FY 2015.
- In FY 2015, VA activated 2.2 million square feet of space for clinical, mental health, long-term care, and associated support facilities to care for Veterans.
- VA held two Access Stand Downs, focusing on patients with the most urgent health care needs first. During a nationwide Access Stand Down that took place on February 27, 2016, the one-day event resulted in VA reviewing the records of more than 80,000 Veterans to get those waiting for urgent care off wait lists; 93 percent of Veterans waiting for urgent care were contacted, with many receiving earlier appointments.
- VA increased its total clinical work (direct patient care) by 11 percent over the last two years as measured by private sector standards (relative value units). This increase translates to roughly 7.4 million additional provider hours of care for our Veterans.
- VA is also working to increase clinical staff, add space and locations in areas where demand is increasing and extending clinic hours into nights and weekends, all of which have helped increase access to care even as demand for services increases.
- In FY 2015, 677,000 Veterans completed more than 2 million telehealth visits, providing enhanced access to care.

The Joint Commission, an independent, not-for-profit organization, accredits and certifies nearly 21,000 health care facilities and programs in the United States. VA's Veterans Health Administration is the largest integrated health care system in the nation, caring for 9 million Veterans. [Source: VA News Release | August 4, 2016 ++]

VA Health Care Surveys

Joint Commission Reports Released

The Joint Commission today provided the results of its Special Focused Surveys of the Department of Veterans Affairs (VA) healthcare facilities to VA leadership. The special focused surveys, prompted by reported allegations of scheduling improprieties, delays in patient care and other quality-of-care concerns, were conducted October 2014 to September 2015 and focused on measuring the progress VA has made to improve access to care and barriers that might stand in the way of providing timely care to Veterans.

"One of my top five priorities is to seek best practices in research, education, and management. We invited The Joint Commission in to conduct these unannounced focused surveys at 139 medical facilities and 47 community based outpatient clinics (CBOC) across the country, to give a better understanding of areas for improvement and areas where the processes are worth replicating," said VA Under Secretary for Health Dr. David Shulkin. The Joint Commission assessed the following:

- Processes related to timely access to care;
- Processes that may potentially indicate delays in care and diagnosis;
- Processes related to patient flow and coordination of care;
- Infection prevention and control
- The environment of care; and
- Organizational leadership and culture.

VA provided The Joint Commission with organization-specific data addressing performance in the key areas targeted for review. This data allowed surveyors to focus on areas of greatest risk for each organization and to validate whether the VA-provided data reflected observed practice. The Focused Survey project provided an opportunity to see patterns across the organization, to make an assessment about the system in general and most importantly, to identify solutions to system-wide issues that are best addressed through internal processes.

"We commend VA for being proactive by requesting The Joint Commission to conduct unannounced site visits at all their medical centers to review and evaluate their efforts to improve access and quality of care. VA was the first system ever to request an assessment with an important focus on access so that deficiencies could be identified and rapidly addressed," said Mark Chassin, MD, FACP, MPP, MPH, president and CEO of The Joint Commission. Chassin also noted, "The Joint Commission will track and report on the extent to which improvements occurred, when the same facilities undergo their triennial accreditation surveys. To date, results from 57 hospitals that have undergone full accreditation are promising. We are pleased with VA's ongoing commitment to quality improvement and patient safety." The full report, with findings and recommendations can be found at: http://www.va.gov/opa/docs/Joint-Commisson-Report-Final-Focused-Survey-Summation-May-2016.pdf . Source: VA News Release | August 4, 2016 ++]

PTSD Update

Marijuana Study | Volunteers Wanted in MD/AZ

Researchers in Maryland and Arizona are looking for veteran volunteers to smoke up to two joints a day in a new study designed to find out if marijuana helps relieve symptoms of post-traumatic stress disorder. "We're not arguing that cannabis is a cure, but our hypothesis is that it will at least reduce the symptoms," says physician and study organizer Dr. Sue Sisley. The $2.2 million study, paid for by a grant from the state of Colorado to the nonprofit Multidisciplinary Association for Psychedelic Studies, will be conducted at John Hopkins University in Baltimore, Maryland, and Sisley's Scottsdale Research Institute in Phoenix, Arizona.

A total of 76 combat veterans will be tested over 12 weeks, but only about four subjects will begin each month across both sites, so the study itself is expected to take two years to complete. More than 100 veterans already have volunteered, Sisley says. Those interested in taking part in Arizona can email their contact information to arizona@marijuanasites.org. Those in the Baltimore area can call 410-550-0050 to register their interest in participating. Initial enrollment is expected to begin in September. The ideal candidate, Sisley says, will have a disability rating from the Department of Veterans Affairs for combat-related PTSD but otherwise be generally healthy and have no other major medical issues.

Those with traumatic brain injuries, however, will be eligible to participate. “We’ve already had quite a few calls from those who’ve experienced military sexual assault. They’ll be eligible, but it can’t be the primary reason for the PTSD. The primary cause must be combat-related,” she says. Candidates should already have been treated for PTSD with therapy and/or prescription drugs but still have symptoms, she says. Study participants can be completely new to marijuana use or already an experienced user, but she recommends against daily users applying for the study because all participants will have to be free from any marijuana use for at least two weeks before beginning the study. “If they’ve already found that it’s beneficial to them, it wouldn’t be ideal for them to just stop,” she says. “That could be pretty brutal for them.”

How it will work.

While anecdotal reports of veterans using marijuana to treat PTSD are on the rise, according to Sisley, this study will be the first randomized, controlled trial in the United States to objectively test it as a legitimate treatment for PTSD. After an initial two-week screening and assessment, participants will be randomly assigned to smoke one of four types of marijuana:

- High levels of THC, or tetrahydrocannabinol, the primary psychoactive ingredient in marijuana that scientists believe acts on receptors in memory and fear processing centers of the brain, according to study documents.
- High levels of CBD, or cannabidiol, which studies suggest may provide an antidepressant-like effect and appears to play a role in reducing anxiety.
- An equal ratio of THC and CBD, which the Veterans Alliance for Medical Marijuana reports to study organizers is generally the favored composition among combat veterans who say they're successfully using marijuana to relieve PTSD.
- A placebo with no significant levels of either THC or CBD.

For the first two days, veterans will be observed for four hours after smoking to insure they don’t experience any adverse reactions. In addition to a physical exam and in-depth psychological assessment, which are repeated at the end of the study, participants will also get regular blood tests and other body monitoring throughout the study. They’ll also be taught the “Fulton Puff Procedure,” which Sisley explains is just a standardized version of the type of smoking common among marijuana users, with a “5-second inhale, 10-second breath hold, 40-second inter-puff interval,” according to study documents.

After an initial battery of tests and assessments, participants will be given weekly supplies of marijuana to use up to 1.8 grams per day. That’s about two joints worth of marijuana per day, but participants will be given a pipe to smoke with and will self-adjust the amount they smoke at any given time. No electronic vaporizers will be allowed. "They use only in response to PTSD symptoms, so they're allowed to use anytime in the day or night," Sisley said. "The veteran is empowered to use however they see fit as long as they don't exceed the 1.8 grams per day." They’ll also be given an iPad to document their use, journal about their experience and video record each time they smoke. They’ll wear a watch designed to track sleep quality.

After the first three weeks, any unused marijuana will be returned and participants will “washout” with no use for two weeks before beginning with another randomized marijuana type, but this time with no chance of getting the placebo. That will be followed by another two-week washout period and a final battery of tests and assessments before participants begin six months of followups, says Sisley, “to get a sense of what choices they make — do they continue to use medical marijuana, pursue some other kind of treatment or something else altogether?” If the trial is successful, officials with the California-based Multidisciplinary Association for Psychedelic Studies, or MAPS, say they intend to seek use of smoked botanical marijuana as a federally approved prescription drug. The U.S. Drug Enforcement Administration gave final approval for the study in April. [Source: Military Times | Jon Anderson + August 2, 2016 ++]

Disabled Vet OPM Sick Leave Update

Final Rule Published

The Office of Personnel Management on 5 AUG was scheduled to publish the final rule implementing a law that gives new federal employees who are disabled veterans the equivalent of a full year's sick leave up front to go to their medical appointments. The 2015 Wounded Warriors Federal Leave Act gives 104 hours of leave immediately to first-year feds who are vets with a service-connected disability rating of at least 30 percent to attend medical appointments related to their disability. It applies to those hired on, or after Nov. 5, 2016, and lasts for 12 months from the date of hire, or the effective date of the employee's qualifying service-connected disability—whichever is later.

"This rule ensures the federal government supports our service members who have sacrificed their own health and well-being to serve our country. We know this is something they need," said acting OPM Director Beth Cobert in a statement on 4 AUG. "We want these veterans to have sufficient leave during their first year of federal service in order to take care of any medical issues related to their service-connected disability."

In addition to eligible new federal hires, the law also will apply to eligible disabled vets who once worked in the federal government, left, and were rehired (with at least a 90-day break in service) to a civil service job on or after Nov. 5, when the law takes effect, according to OPM. Federal employees who take a break from their civilian jobs to serve in the military and are injured during that service also would be eligible for disabled veteran leave when they return to their civilian jobs. For disabled vets in those categories, the amount of leave they receive for medical appointments would be offset by any existing sick leave they had. So, if the disabled vet is re-employed with the government and has 30 hours of existing sick leave from his prior job, then his disabled veteran leave bank would include 74 hours to attend medical appointments related to his service-connected injury.

The Federal Managers Association, which helped bring the issue of leave for disabled veterans to the attention of lawmakers, praised OPM and Cobert's leadership in drafting the final rule. "The rule not only remains loyal to the congressional intent of the bill, but also extends the new leave to the broadest number of potentially eligible disabled veterans," said FMA National President Renee Johnson. OPM also said it would calculate the correct number of leave hours for those eligible disabled vets who are part-time or seasonal employees, since the 104-hour benefit is based on a full-time employee's work schedule. OPM said it would encourage agencies to make new employees aware of the benefit, and "in the coming weeks" would provide more information to agencies to ensure they know how to implement the new leave category.

The Wounded Warriors Federal Leave Act directs agencies to create a separate leave category – apart from regular sick leave – for eligible employees. During their first year on the job, those vets would still accumulate their normal sick leave. The employees only would be able to use their disabled veteran leave for treatments directly related to their service and would not be able to carry over the one-time "wounded warrior leave" after the first 12 months on the job. The benefit under the law applies only to those newly-hired feds who are covered under Title 5 leave provisions, and includes employees of the Postal Service and Postal Regulatory Commission. Non-Title 5 disabled veteran employees, including those at the Federal Aviation Administration and Transportation Security Administration, are not eligible for the new benefit. Many jobs at the Veterans Affairs Department, for instance, also are not covered under Title 5. Title 5 governs most, but not all, of the federal personnel system.

Prior to the new law, full-time federal workers in their first year on the job did not have access to sick leave until they had been in the job long enough to earn the benefit, typically accruing four hours of such leave per pay period. That amounts to a balance of 104 hours at year's end. But disabled vets, who must attend regular medical appointments to maintain their health and to continue receiving their veterans' benefits, can burn up their sick leave quickly.

"As the final rule is published and the law soon takes effect, I am humbled and immensely proud this originated from Sue Thatch, an FMA member from Chapter 21, Marine Corps Air Station Cherry Point [N.C.], who saw a need and pursued a remedy," Johnson said. "Watching this idea become a bill and then signed into law shows what is possible when Congress and the administration come together for the common good." Current federal employees who are disabled veterans are not eligible for the new type of leave. Those workers qualify for other types of leave and flexibilities to receive treatment

for service-connected disabilities, including leave without pay, annual leave, sick leave, advanced sick leave, alternative work schedules and telework.

Clarification: As explained in the story, "wounded warrior" leave is a separate leave category from sick leave. But the amount of "wounded warrior" leave (104 hours) is equivalent to a year's worth of sick leave. [Source: GovExec.com | Kellie Lunney | August 4, 2016 ++]

Vet Employment

What's Really Going On | CNAS Survey

After 15 years of war, there are big questions over how well the men and women who serve the country are faring after military service. The Center for a New American Security (CNAS) is launching a survey of veterans, HR professionals, and supervisors to figure out what's affecting veterans' performance in the workplace. By taking a better look at the challenges that exist for vets, we hope to find better ways to help them as they leave the military.

In response to a surge of unemployment for post-9/11 veterans, many groups launched fantastic efforts to address the problem. From the Veterans Jobs Mission to the Joining Forces initiative at the White House, both the public and private sector stepped up to the plate, seeing a moral obligation to help and that hiring veterans is smart business. After several years of these efforts, veteran unemployment is on the decline, but it's still difficult to know how veterans are doing in the economy long term. We don't know if veterans are succeeding in building careers over time, the impact of how long they stay in their first job, and what the challenges are in transitioning from the military into a new company culture. The CNAS survey attempts to gather more information about veteran economic performance, to use it to shape programs aimed at recruiting veterans and keeping them employed.

There are several important aspects to the economic performance of veterans, from their initial recruitment into their first post-military job, to whether employers are aware of the benefits of hiring veterans and their families. Also, often veterans take jobs that are not in line with their skills and values. Without further data, it will be difficult to figure out how much this is the case, and what the primary causes are. While it's possible that veterans are receiving better offers from other companies or moving onto higher-level positions elsewhere, veterans may be struggling to assimilate into civilian culture or finding it difficult to see the impact of their work. By gathering more information we can begin to better understand this phenomenon and where we need to help. [Source: Task & Purpose | Amy Shafer And Andrew J. Swick | August 9, 2016 ++]

Homeless Vets Update

Reduced by Half Since 2010

The U.S. Department of Housing and Urban Development (HUD), U.S. Department of Veterans Affairs (VA), and the U.S. Interagency Council on Homelessness (USICH) announced 1 AUG the number of veterans experiencing homelessness in the United States has been cut nearly in half since 2010. The data revealed a 17-percent decrease in veteran homelessness between January 2015 and January 2016—quadruple the previous year's annual decline—and a 47-percent decrease since 2010. Through HUD's annual Point-in-Time (PIT) estimate of America's homeless population, communities across the country reported that fewer than 40,000 veterans were experiencing homelessness on a given night in January 2016. The January 2016 estimate found just over 13,000 unsheltered homeless veterans living on their streets, a 56-percent decrease since 2010. View local estimates of veteran homelessness.

This significant progress is a result of the partnership among HUD, VA, USICH, and other federal, state and local partners. These critical partnerships were sparked by the 2010 launch of Opening Doors, the first-ever strategic plan to prevent and end homelessness. The initiative's success among veterans can also be attributed to the effectiveness of the HUD-VA Supportive Housing (HUD-VASH) Program, which combines HUD rental assistance with case management and clinical services provided by the VA. Since 2008, more than 85,000 vouchers have been awarded and more than 114,000 homeless veterans have been served through the HUD-VASH program.

- "We have an absolute duty to ensure those who've worn our nation's uniform have a place to call home," said HUD Secretary Julián Castro. "While we've made remarkable progress toward ending veteran homelessness, we

still have work to do to make certain we answer the call of our veterans just as they answered the call of our nation."

- "The dramatic decline in Veteran homelessness is the result of the Obama administration's investments in permanent supportive housing solutions such as HUD-VASH and Supportive Services for Veteran Families (SSVF) programs, extensive community partnerships, coordinated data and outreach, and other proven strategies that put Veterans first," said VA Secretary Robert A. McDonald. "Although this achievement is noteworthy, we will not rest until every Veteran in need is permanently housed."
- "Together, we are proving that it is possible to solve one of the most complex challenges our country faces," said Matthew Doherty, Executive Director of the U.S. Interagency Council on Homelessness. "This progress should give us confidence that when we find new ways to work together and when we set bold goals and hold ourselves accountable, nothing is unsolvable."

In 2014, First Lady Michelle Obama launched the Mayors Challenge to End Veteran Homelessness with the goal of accelerating progress toward the ambitious national goal of ending veteran homelessness. More than 880 mayors, governors, and other local officials have joined the challenge and committed to ending veteran homelessness in their communities. To date, 27 communities and two states have effectively ended veteran homelessness, serving as models for others across the nation. HUD and VA have a wide range of programs that prevent and end homelessness among veterans, including health care, housing solutions, job training and education. In FY 2015, these programs helped more than 157,000 people—including 99,000 veterans and 34,000 children—secure or remain in permanent housing. Since 2010, more than 360,000 veterans and their families have been permanently housed, rapidly rehoused or prevented from becoming homeless through programs administered by HUD and VA.

More information about VA's homeless programs is available at www.va.gov/homeless . More information about HUD's programs is available at or by calling the HUDVET National Hotline at (877) 424-3838 or at http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless. Veterans who are homeless or at imminent risk of becoming homeless should contact their local VA Medical Center and ask to speak to a homeless coordinator or call 1-877-4AID-VET. [Source: VA News Release | August 1, 2016++]

Women Congressional Vets

Legislative Impact

There are now four female combat veterans in Congress. And they have something to say about the changing face of the Armed Forces, which is officially open to women joining combat units across the board. The Washington Post is exploring how women gain, consolidate and experience power in politics and policy. They are a diverse group: Rep. Tammy Duckworth (D-IL) is a former Black Hawk helicopter pilot, and Rep. Tulsi Gabbard (D-HI) served in the military police in Kuwait. Rep. Martha McSally (R-AZ) flew A-10s for the Air Force, and Sen. Joni Ernst (R-IA) served in the Iowa National Guard.

But they are speaking together in Congress just as the Pentagon is implementing sweeping changes to the face of the military. And as they raise their voices, their colleagues are listening to them on issues such as sexual harassment in the military, expanding family leave and planning options for soldiers, and – most recently – whether women should be eligible for the draft. "There's still a lot of misperception that exists and a lot of misinformation, though by and large most people are sincerely interested in learning more and hearing more from us" about women in combat roles, Gabbard said in an interview. "We're coming at this as a continuation of the service to our country."

The foursome is hardly a sisterhood-in-arms – they are divided ideologically, and their interactions outside of the Armed Services committee rooms are relatively infrequent, although Gabbard and McSally belong to the same morning workout group. But in a short period of time, the women have become go-to authorities in a legislative arena traditionally dominated by men – and especially male veterans. And their experience in the male-dominated military has taught them important lessons about how to survive in Washington. "I mean, it [Congress] is a male-dominated institution … so it felt very, um, 'familiar' is probably the right word," McSally said in an interview, laughing. "But I learned a lot along the way in the military on how to figure out how to be credible, respected and effective in that environment, when you are potentially the only woman at the table."

Of the 102 veterans serving in Congress, these four are the only women. Each is fiercely proud of her military service and looks back fondly on the bulk of her interactions with fellow soldiers, commanders and underlings in the military. But each also has distinct memories of how being a woman in uniform meant being treated differently.

- "There were different missions I had volunteered for, along with other females in our unit, and we were told we weren't allowed to participate in those missions simply because we were female," Gabbard recalled of her time as a military police platoon leader in Kuwait.

- "When I was overseas, I had two senior officers from another battalion who were not good to deal with," Ernst said, alluding to overt harassment during her deployment with the Iowa National Guard. "Sexual harassment certainly exists."

- For McSally and Duckworth, the differences were palpable before they even left basic training. McSally wanted to be an Air Force doctor, but "the reason I decided to be a fighter pilot," she explained, "is because they said that I couldn't." "It motivated me to just say, you know, this is wrong, and I'm going to be a part of proving that it's wrong," she said.

For the female Republican veterans especially, issues pertaining to women in combat can put them at odds with their party leadership. But change from within the system, they say, is part of the job. "I joke that I believe part of my calling in life is to create cognitive dissonance in people. First it was 'women warriors,' and now it's 'feminist Republican,' " McSally said. "But just to clash people's stereotypes and make them have to choose." "We have very few people that actually have backgrounds in national security," she continued. "So when I speak on a variety of issues, hopefully they take that into consideration."

Duckworth has a similar story: She entered the Army speaking four languages and thinking she would become a linguist. But when her superiors told her, as the only woman in her graduating class of ROTC cadets, that she didn't have to consider combat roles like her male colleagues, she changed her mind. "It's why I became a helicopter pilot," Duckworth said. "And what I love about the military is if you can do the job, then you're part of that group – at the end of the day, it's the ultimate meritocracy." But as lawmakers, getting people to hear their arguments about women in the military can be hard. Often, the female veterans find themselves repeating the same points to colleague after colleague, person after person, trying to change minds one by one.

The latest issue requiring a sustained persuasion campaign is the debate about whether women should be subject to the draft – something all four female combat veterans favor, even though none of them believe a draft is still necessary. "It's about equality," said Duckworth, a former Army pilot whose Black Hawk helicopter and was shot down over Iraq in 2004. "If we're going to have a draft, then everyone should register," she said. Male veterans in Congress started the debate as a way of challenging President Obama's recent decision to open all U.S. military combat roles to women. But the effort to shock lawmakers into repudiating the new policy backfired when a majority of House and Senate Armed Services committee members supported the change to have women ages 18 to 25 register for the Selective Service.

GOP leaders have tried to stamp out the issue, stripping the draft language from the House's defense policy bill and releasing a convention party platform opposing women in combat. The question will ultimately be resolved later this year when Congress finalizes a defense policy bill. But in the meantime, the four women have been pushing back against the most common emotional arguments surrounding the draft — that is, no one would want their own wife, sister or daughter risking her life on the front lines. "It's a 'gotcha' — because 'women shouldn't be in combat. … I'm going to make your daughter sign up,' " Duckworth said, shrugging. "Great. I'll go register her right now, she's 18 months old." Said Ernst: "I believe we all need skin in the game, and my daughter will turn 18 here in a little over a year. And certainly — do I think she should sign up? Yes, I do. So it is personal to me." The issue of women in the draft is just one of many traditionally driven by male veterans on topics such as wars, weapons systems and persistent reports of sexual assault in the military.

Congress's female veterans rarely agree unanimously on any major military issue other than the role of women in combat, now playing out in the debate over the draft. All favor instituting standards and policies that would help recruit and retain more female troops. But they differ over how to address the scourge of sexual harassment in the services, and the extent to which the government should shoulder the cost of more parental-leave and fertility-assistance options for enlisted

soldiers. On the question of fertility assistance, Duckworth, Gabbard and McSally support a new Pentagon pilot program to help service members continue to have children even if injured in combat. But Ernst says it's not always feasible to pay for such measures — desirable as they may be — while the Defense Department is in a budget squeeze.

They are also divided on how to respond to sexual assault in the military, an issue of heated debate in the Senate, where Sens. Kirsten Gillibrand (D-N.Y.) and Claire McCaskill (D-Mo.) – neither of whom served in the military – have been driving the standoff over whether cases should be prosecuted outside the chain of command. Democrats Duckworth and Gabbard support Gillibrand's approach to take such cases out of the chain of command and hand them over to a military prosecutor. Gabbard has led that legislative effort in the House. But Republicans McSally and Ernst – who has dealt with a situation in which a soldier under her command was accused of rape – both said they are seeing enough progress to allow commanders to consider the issue. Still, both took deep breaths before answering this question, adding that they reserved the right to change their minds if the military does not continue to significantly improve in this area.

The four have, however, found common cause in less politically divisive initiatives, such as McSally's bid to secure burial rights for female World War II pilots at Arlington National Cemetery, a bill that became law this spring. As for the draft and women serving in combat roles, all four are united in advising their colleagues against typecasting. Some of the four would also like to use their influence to shed light on lower-profile issues affecting women in the military

- Elements of basic procurement may have to change, Duckworth said, recalling how the cut of her flight suit made the prospect of going to the bathroom while on mission a near-impossibility. As women move into new combat roles, the Pentagon and defense contractors will have to make changes to accommodate women's bodies.
- Establishing achievable but fair performance standards for women is more complicated than it seems, Ernst warned.
- Even haircut policies can cause a problem, McSally said. Letting women evade the traditional buzz cut "can add to resentment" or allegations of special treatment for women, she said.

Some things, the female veterans argue, will just be worked out in time as the military matures to accept and promote more women, such as Air Force Gen. Lori Robinson, who in May became the military's first female combatant commander. "As we get more women from my generation who served in combat roles and who actually saw real combat move up … you're going to see some of the problems get more attention and be resolved," McSally said. But generational changes come slowly. And so all four are committing themselves to a long road ahead. "I've lived through this nonsense for 26 years," McSally said, referring to stereotypes about women in the military. "It's a part of my journey in service. If you've got to change people's minds one at a time, then you need to do it." [Source: Washington Post | Karoun Demirjian | August 2, 2016 ++]

Veterans Omnibus Bill Update

Hits Stumbling Block in Senate

Veterans Affairs Secretary Bob McDonald has described 2016 as a "make or break year" for the department. But the outcome largely depends on whether Congress can pass major legislation to change the disability appeals process, access to VA health care and accountability procedures for senior executives at the department. The Senate Veterans Affairs Committee and the department itself is touting the Veterans First Act as the best case scenario. But the omnibus' main sponsor said the bill still has a long way to go before it heads to the President's desk. "It's comprehensive and it's sweeping, and because of that, it's not going to be the easiest thing in the world to ever pass," Senate Veterans Affairs Committee Chairman Johnny Isakson (R-Ga.) said at a 31 JUL discussion at the annual Disabled American Veterans national convention in Atlanta.

Isakson had said his original hope was to have the bill to the President by Memorial Day. "We've hit a couple stumbling blocks in the Senate, so I have not yet gotten it to the floor for a debate," he added. "I'm trying to get unanimous consent to do that when we get back. … We aren't to the nobody objecting point yet. But it's on varying degrees of change they want to make, not on being against the accountability portion."

House VA Committee Chairman Jeff Miller (R-FL) introduced an alternative bill that would significantly change the discipline and appeals process for VA senior executives and the secretary. The VA Accountability First and Appeals

Modernization Act addresses the very provision that the VA announced it would no longer use following a recent decision on its constitutionality from the Justice Department. “Rank and file employees of the system have nothing to fear about accountability,” Isakson said. “The leaders of the organization ought to have everything to fear about accountability … The higher the expectation standards are of the organization, the higher the performance is going to be by the employees up and down the line.” Isakson said he hopes that either he or Miller can push one of their bills to a full vote, with the goal that the two chairman can come together for conference on both pieces of legislation.

The Senate omnibus has 148 different provisions but doesn’t yet include the VA’s proposal to change the disability appeals process. McDonald said he hoped the Senate would add it as an amendment or pass it as a separate bill. “The problem is that perfection is never possible,” Isakson said. “We’re at a point where we have 80 percent of what we need to get to improve the veterans administration, give Bob McDonald the clout that he needs.” Both Isakson and McDonald encouraged audience members to call their congressman in support of the Senate omnibus.

A preview of the Commission report

The House Veterans Affairs Committee is expected to review the VA Commission on Care report, which the group officially released at the end of June, during a hearing in September. McDonald, who said he detailed his view on the Commission’s recommendations in a report to President Barack Obama, offered a preview. Twelve of the 18 recommendations are consistent with the goals and proposals McDonald has outlined as MyVA transformation priorities, he said at the DAV convention. McDonald believes three of the commission’s recommendations need more study, such as the suggestion that VA trim and update its real estate portfolio. And there’s three recommendations that McDonald and the agency “totally disagree with,” he said.

Specifically, McDonald opposes the commission’s proposed changes to the honorable discharge procedures, as well as its recommendations to shift more VA health care to private providers and add an 11-member governance board. “It appears to be almost a Trojan horse for privatization,” McDonald said of the commission’s report. Under the commission’s proposal, veterans would have the option to choose between the VA or a private provider, regardless of whether the Veterans Health Administration could provide that care or not. McDonald said the suggestion contradicts a concept he’s been trying to build on since he arrived at the department. “What we’re trying to do right now with the MyVA transformation is actually integrate VA, so that the veteran can go to any employee at the VA and learn about any other part of VA,” he said.

The VA secretary would also lose oversight over the VHA, according to another Commission proposal. The secretary would have a seat on the 11-member governance board, but the group itself would have ultimate control and oversight over the Veterans Health Administration, not the secretary. “I don’t think that’s necessary,” McDonald said. “The Veterans First Act shows very clearly that Congress can work with the VA on behalf of veterans. I don’t think a surrogate is required. I also question the Department of Justice’s question on the constitutionality of that, because it’s in a sense Congress controlling part of the Executive Branch.” [Source: Federal News Radio | Nicole Ogrysko | August 4, 2016 ++]

Vet Status/Preference Progress

H.R.1384, S.743 & H.R.5526

Two no-cost initiatives to honor the service of Reserve and National Guard members are edging forward in Congress, though final passage this year is still far from certain. The more familiar of the two bills would bestow honorary “veteran” status on up to 200,000 Reserve and National Guard retirees who can’t now be called military veterans as defined under federal law. A newer initiative, being pushed by Reserve Officers Association, would make many more former Reserve and Guard members who were called to active duty under support orders eligible for veteran preference in competing for federal civilian jobs. Here’s a status report on both:

Honor America’s Guard-Reserve Retirees Act (HR 1384, S 743)

Every year more reserve component retirees learn to their surprise that they cannot claim to be veterans, despite part-time careers in service to the nation. These are retirees who were never ordered to active duty other than for initial training and brief periods of annual training. In recent years the lack of veteran status for these retirees stung a bit more with every failed attempt by proponents in Congress to win for them honorary veterans status. Inevitably, it seemed,

either the Senate or the House or both fumbled the initiative during a final frantic year-end rush to complete neglected work on behalf of veterans. Particularly frustrating for backers of the Honor America's Guard-Reserve Retirees Act, which has been introduced in the last four Congresses, is that the bills have no cost. The most recent versions specifically state that the reserve component retirees being honored with veteran status "shall not be entitled to any benefit by reason of this honor."

The House last November passed H.R.1384 by a vote of 407-to-0. Referred immediately to the Senate, it languished there until May when the veterans affairs committee finally made it part of a massive legislative package called the Veterans First Act (S.2921). The showpiece of that bill is a $3.1 billion plan to phase in for older generations of severely injured veterans the caregiver benefits enacted in 2010 for Post-9/11 veterans. That provision also might be the bill's fatal flaw if the House rejects the idea. House Veterans Affairs Committee Chairman Jeff Miller (R-Fl) last May signaled through a committee spokesman that he doesn't favor expansion of the caregiver program until a rash of problems with the current program, documented by congressional auditors, have been addressed.

On 2 AUG a House committee spokesman also noted pointedly that 30 separate House-passed veterans bills still await Senate consideration. The tone suggests the two chambers are far apart on how to tackle veteran reform initiatives issues, particularly with a long summer recess and elections this fall shrinking the number of days Congress will be in session. Senate leaders allowed all of June to pass without a floor vote on the Veterans First Act and then adjourn until September. That leaves a lot less time for House and Senate conferees to reconcile very different approaches taken this year on more critical veteran issues. Time will tell if the honorary veteran status language survives to be included in a final veterans omnibus bill or if it gets ignore again during tough negotiations on a lot of other matters, including this year the caregiver expansion favored by the Senate and tougher accountability rules for VA executives sought by the House.

Reserve and Guard Veterans Preference

Rep. Brad Wenstrup (R-OH) has introduced a bill, H.R.5526, to improve VA hiring procedures that includes language to extend veterans preference for federal jobs to more Reserve and National Guard members who have been called to active duty. The veteran preference initiative was conceived by Reserve Officers Association to better recognize the wartime contributions of today's "operational" reserve components in contrast to the largely standby role for reserve forces during the Cold War era. The bill, introduced last month, would confer veteran status for the purpose of federal hiring on any reserve component member who has 180 "cumulative" days on active duty under call-up orders. That would relax a current requirement of 180 "consecutive" days for Reserve and Guard to gain veteran preference.

Many of the 900,000 Reserve and Guard members activated for the Iraq and Afghanistan wars, and of the 250,000 reservists activated for the first Gulf War of 1990-91 were called up for periods well short of 180 days. In urging leaders on the veterans affairs committees to support the measure, Jeffrey Phillips, executive director of ROA, noted in a letter that Congress has extended veterans' preference for federal jobs to parents of veterans who died or became severely disabled while serving their country. Commending that development, Phillips argued that the change now sought would recognize the recent pattern of operational support provided by Reserve and Guard, with many serving multiple tours of less than six months, too short to qualify for veteran preference under current law. "They should not be penalized for the nature of their service," he said. "By being available for shorter durations, Guard and Reserve members demonstrate the flexibility the nation needs, in a cost-effective manner."

He noted that these same members could serve 20 years or more and not accrue the 180 consecutive days of active service needed under current law to qualify for veterans' preference. Phillips described the initiative as a "virtually cost-free" to "correct this situation and to facilitate employment among our reserve components even as they support the nation."

In a phone interview Phillips and Susan Lukas, director of legislative policy for ROA, said no lawmaker has so far objected to the initiative, a promising sign for inclusion in any omnibus veterans package passed by year's end. Passage as a standalone bill would be more difficult because H.R.5526 has 14 other provisions, some of which do have costs. Indeed a House committee spokesman said "the future of H.R.5526 is uncertain because Democrats oppose any offset that would pay for the bill, and have put forth no viable alternatives for offsetting the bill's cost." [Source: Military Update | Tom Philpott | August 4, 2017 ++]